Department of Health
Child and Adolescent Mental Health Division

Performance Report

Performance Period April 2006-June 2006

Introduction

This report presents findings about the performance of operations and services of the Child and Adolescent Mental Health Division (CAMHD) during the fourth quarter of fiscal year 2006 (April 2006-June 2006). The information used for this report is based on the most current data available, and where possible are aggregated at both statewide and district or complex levels. Tracking and analyses of data provides information that allows stakeholders to determine how well CAMHD is delivering care and impacting child outcomes.

Data in this report are presented for four major areas:

- Population: Population information describes the demographic characteristics of the children and youth served by CAMHD.
- Service: Service information is compiled regarding the type and amount of direct care services provided.
- Cost: Cost information is gathered about the financial aspects of services.
- Performance Measures: Performance Measures, including Outcome data, are used to understand and track the quality of services over time and the performance of operations of the statewide infrastructure designed to provide needed supports for children, youth, and families. Outcomes are further examined to determine the extent to which services that are provided lead to improvements in the functioning and satisfaction of children, youth and families.

How Measures Are Selected and Used

CAMHD uses performance measures throughout its program to measure quality and performance and to align organizational goals with achieving results in core areas of service provision and supporting infrastructure. Measures are used to coordinate the work of the organization in order to achieve timely, cost-effective services that ultimately improve the lives of children, youth and families served.

The CAMHD Performance Management system allows CAMHD, at all levels, to look at its performance and use this information to make decisions about adjustments to its program. Performance data in CAMHD are tracked systematically across all aspects of service delivery and care. Services are monitored through tracking of trends and patterns found in utilization, program performance and satisfaction data, and examinations of practice and quality of services. This information helps determine how well the system is doing for youth, and how well youth are progressing. It is sensitive enough to ascertain if the system is performing better or worse for certain populations, and comprehensive enough to detect what aspects of care, and in what settings, problems may be occurring.

Further studies and special reports on the CAMHD population and services, including past editions of this report can be accessed at the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/resources/index.html.

Quality Improvement Highlights during the Reporting Quarter

Highlights of key activities conducted during the quarter include:

- Awards were made to agencies pursuant to the CAMHD Request for Proposals for Home and Community-Based Services. Several specific services, and services in particular communities were not awarded due to non-response, and a new RFP will be issued in the next several months to address these services and communities.

- In the quarter, CAMHD was reviewed by an External Quality Review Organization (EQRO), the Health Services Advisory Group, which measures compliance with Medicaid rules for Managed Care Organizations. The EQRO conducted an intensive review of CAMHD's systems for providing quality services including its quality management program, utilization management program, care coordination system, and grievance management system. CAMHD did very well across all areas reviewed, and received a 99% overall score.

- The federal Substance Abuse and Mental Health Services Administration (SAMHSA), has notified Hawaii that we have been awarded a multi-year Mental Health Transformation grant. CAMHD collaborated with the Adult Mental Health Division in the grant application. This prestigious award will allow Hawaii to develop policy initiatives across state departments and the community to transform the mental health services delivery system. Although Hawaii has made great strides over the last decade, much work remains to assure that every individual with mental health issues can have a life in the community.

- The CAMHD Statewide Management Team (SMT) convened to further the development of CAMHD's new Strategic Plan that will cover the next four years (2007-2010). Meetings with stakeholders throughout the state were conducted during the quarter to gather input into shaping CAMHD's priorities. The SMT will be developing the actual plan using the data gathered during work sessions to be head in August.

- CAMHD staff and stakeholders presented by invitation at the Georgetown University Center for Child and Human Development Training Institutes 2006 in Orlando. The theme of the Institutes focused on service delivery approaches that are family driven, youth guided, and individualized and that represent evidence-based or promising practices that achieve positive outcomes for children and their families. Presenting for CAMHD were Christina Donkervoet, CAMHD Chief; Susan Cooper, Executive Director of Hawaii Families as Allies; Mary Brogan, Performance Manager; and Eric Daleidan, Research and Evaluation Specialist.

  The Institute presented by CAMHD was entitled, Integrating Perspectives to Conduct Useful Evaluation to Improve Services and Systems of Care. It focused on how to conduct evaluations in systems of care that provide useful information to improve programs and practice, and how to involve key stakeholders and their varying perspectives in conducting such evaluation activities. Based on experience

in Hawaii, the Hawaii faculty shared strategies for involving families and youth in evaluation activities, outlining the key roles that they play in evaluating and managing the systems of care.

The various aspects of Hawaii's evaluation activities were also shared including monitoring quality, systematic evaluation of treatment progress in individualized care, and measuring cost-quality efficiencies – with specific information presented to help participants learn how to implement similar strategies in their states and communities. In the area of monitoring quality, introduced was Hawaii's framework and structures for supporting continuous quality improvement, including the case-based quality review process and reporting system; the method for engaging in interagency quality assurance activities involving DOE, CAMHD, Child Welfare, and Early Intervention; strategies for meeting Medicaid's comprehensive quality assurance requirements for managed care entities; and the method for monitoring the quality of the coordinated service planning process.

In the evaluation of individualized care, highlighted were the measures used to assess child status and progress; standardized assessment of functional status (CAFAS); the targeted implementation of service initiatives (including Evidence-Based Services, Multi-Systemic Therapy, and the Hawaii Youth Initiative); the Monthly Treatment and Progress Summary (MTPS); the results of longitudinal evaluation using the MTPS and CAFAS; and issues of drawing generalized and programmatic conclusions from individualized evaluation and treatment.

The CAMHD team also introduced cost-quality analyses as an important tool for evidence-based management of a mental health system, illustrating the use of Data Envelopment Analysis (DEA) and its basic procedures including the results of the most recent DEA analysis of Hawaii's community systems of care and how results are incorporated into management discussions.

Overall Summary of Findings

The overall results for the reporting quarter, based on analysis of performance presented in this report suggest that in many areas, CAMHD's functioning is comparable to that of previous quarters. However, due to the continued and growing problem of vacancies experienced across the Division, there was erosion in a number of critical areas including caseloads, access to services, consumer satisfaction, Family Guidance Center performance, and committee measures. Almost half (45%) of CAMHD's measures were not met in the quarter compared to 21% last quarter.

Human resources, particularly hiring and retaining qualified mental health care coordinators and central office administrative staff continue to challenge CAMHD's ability to maintain a stable service delivery infrastructure. The total number of youth served declined, and the total size of the CAMHD population was smaller this quarter than it was a year ago. Service utilization trends for Hospital continued to decrease, and the use of Community Residential services reversed the increase seen last quarter. Utilization of Therapeutic Foster Homes also continued to decrease over previous quarters, but increased over the same period last year.

Overall, core infrastructure measures are showing signs of impacting other areas of CAMHD's operations. These trends and the reasons for current performance suggest that

policy-level interventions are needed to ensure that the gains that have been made are sustained.

Data Sources

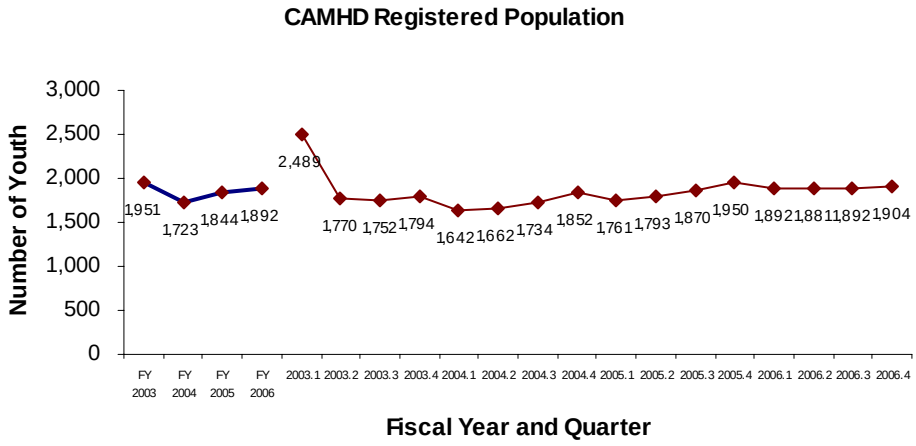
Data regarding the population served, access and use of services, cost, treatment processes and outcomes is generated at the Family Guidance Centers or through billing information, and collected through the Child and Adolescent Mental Health Management Information System (CAMHMIS). CAMHMIS produces data reports that are used by staff and management for tracking, decision-making, supervision and evaluation. CAMHMIS' multiple features include the ability to generate "live" client data, FGC-specific reports and other special reports that aid in performance analysis and decision-making. Additional data elements used to track Performance Measures are produced by various databases maintained at the State Level.

Population Characteristics

Population data presented here are for youth registered through the CAMHD Family Guidance Centers during the fourth quarter of fiscal year 2006 (April 2006-June 2006). In the quarter, CAMHD Family Guidance Centers provided care coordination for 1,904 youth across the State, an increase of 12 from the previous reporting quarter (January 2006-March 2006 based on data as of March 31, 2006), or a 1% increase in the total population over last quarter. Increases in the registered population were experienced in more than half of the Family Guidance Centers.

The trend of overall year-to-year growth reversed this quarter. In comparison to the same period of last year (April 2005-June 2005), CAMHD has experienced a 2% overall decrease in its registered population. Although this quarter's numbers registered continued to rebound, CAMHD serves fewer youth than expected based on estimates of the prevalence of severe emotional and behavioral problems in the general population. Access to the population that need and qualify for CAMHD services is a clear need.

The chart below reflects changes in the CAMHD population over time.



Note: The drop in population at the start of fiscal year 2003 (July 2002) corresponds to the shift in management of services to youth with pervasive developmental disorders from CAMHD to the Department of Education.

The numbers of youth registered during the fourth quarter at each of the Family Guidance Centers are displayed in Table 1 below.

Table 1. Population of Youth Registered by Family Guidance Center

	COFGC	LOFGC	MFGC	WFGC	HOFGC	HFGC	KFGC	FCLB
Fourth Quarter FY 2006	146	252	158	148	164	460	522	51
Third Quarter FY 2006	151	244	165	133	163	454	536	44
Fourth Quarter FY 2005	167	244	167	151	183	471	527	40

Please note that the numbers for Kauai (KFGC) are for the Mokihana Project in total, which serves youth with both low and high intensity mental health needs. Also displayed are the numbers for the preceding quarter (Quarter 3, FY 2006), and the numbers for the same period one-year ago (Quarter 4, FY 2005). The data show that there have been some minor but not significant fluctuation in population among the Family Guidance Centers, but overall the population has remained fairly stable over the last year.

In the current quarter (Quarter 4, FY 2006), the largest population, consistent with historical data, continued to be served on the Big Island through the Hawaii Family Guidance Center (HFGC). HFGC served 24.2% of the total CAMHD population during the quarter. The Leeward Family Guidance Center (LFGC) served the largest population on Oahu, which is 13.2% of the CAMHD registered youth. The Family Court Liaison Branch (FCLB), which provides services primarily for incarcerated and detained youth, continued to serve the smallest registered population (2.7%).

The total number of registered youth are described by four subgroups: (*i*) youth who received both intensive case management services and direct services authorized through the CAMHD provider network, (*ii*) youth who were in the process of having services arranged (new admissions), (*iii*) youth who received less intensive services through Mokihana on Kauai, and (*iv*) youth who were discharged at some time during the quarter. There is also a percentage of youth who receive intensive case management services only. Of the total number of registered youth, 978 had services that were authorized within the quarter.

Of the total registered population statewide (1,904), 151 youth (7.9%) were newly registered (had not previously received services) in the fourth quarter of fiscal year 2006. This represents an increase of 13 new admissions from the previous quarter (January 2006-March 2006). One hundred nine (109) youth (5.7%) who had previously received services from CAMHD were reregistered, a slight increase from last quarter's readmissions of 107 youth. CAMHD discharged a total of 248 youth during the quarter, or 13.0% of the registered population. This is an increase of 53 youth from last quarter's discharge of 195 youth, which was 10.3% of the registered population. Because youth may receive multiple admissions or discharges during the quarter for administrative reasons, these numbers estimate, but do not exactly reflect changes in the overall registered population size. Youth are generally discharged for several reasons, which can include attaining desirable treatment outcomes, graduation from school or "aging-out" of services, treatment refusal or program elopement, or moving out of state.

This pattern of admissions and discharges suggests that the reduction in the total registered population is resulting from a decrease in the number of new admissions, not an increase in the number of discharges. In other words, the services for youth registered with the system apparently proceeded as is typical, but "pathways" into the system provided fewer youth.

The average age and age range has remained relatively stable among the CAMHD population over the past few years. The average age of registered youth in the reporting quarter was 14.3 years with a range from 3 to 20 years. Approximately two-thirds (66%) of youth served during the fourth quarter were male (see Table 2), a continued trend.

Table 2. Gender of CAMHD Youth

Gender	N	% of Available
Females	642	34%
Males	1,262	66%

The national origin of youth is displayed in Table 3. The races of youth registered in the reporting quarter are displayed in Table 4. The valid completion rates for the new procedures continued to be low with 64.7% of youth missing national origin information and 48.6% of youth missing race information, which continues to limit the generality of the available data. Race data were somewhat less available this quarter than last quarter when 41.5% had race data recorded. However, the observed results for both data sets continued to be relatively consistent with prior quarters. A recommendation to improve completion rates will be made to the CAMHD Performance Improvement committee, as data completion for race and national origin has historically been low.

In the quarter, multiracial youth represented the largest racial group (62.5%), followed by White youth (16.3%), and then Native Hawaiian or Pacific Islanders (10.2%).

Table 3. National Origin of Youth (Unduplicated)

National Origin	N	% of Available
Not Hispanic	464	68.9%
Hispanic or Latino/a	209	31.1%
Not Available (% Total)	1,231	64.7%

Table 4. Race of Youth (Unduplicated)

Race	N	% of Available
American Indian or Alaska Native	1	0.1%
Asian	81	8.3%
Black or African-American	15	1.5%
Native Hawaiian or Pacific Islander	100	10.2%
White	160	16.3%
Other Race	10	1.0%
Multiracial	612	62.5%
Based on Observation	134	13.7%
Not Available (% Total)	925	48.6%

Subpopulations of youth who receive services through CAMHD are also involved with other public child-serving agencies. These agencies include the Department of Human Services (DHS), Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home, and the Med-QUEST Division of DHS (see Table 5). In the quarter, 8.4% were involved with DHS, which continues a multiyear pattern of a progressively smaller proportion of youth involved with DHS (e.g., 9.6% during the same period of FY 2005). At some point during the quarter, 22.1% had a Family Court hearing during the quarter, and 4.8% were incarcerated at HYCF or detained at the Detention Home. Both of these proportions decreased slightly from the previous quarter (22.9% and 5.3%, respectively) and remain below the same period from last year (23.4% and 6.3%, respectively).

Table 5. Agency Involvement

Agency Involvement	N	%
DHS	159	8.4%
Court	420	22.1%
Incarcerated/Detained	92	4.8%
SEBD	799	42.0%
Quest	723	38.0%

Services to youth who are QUEST-eligible and have a Serious Emotional and Behavioral Disturbance (SEBD) occur by virtue of a Memorandum of Agreement (MOA) with the Med-QUEST Division. Youth who were eligible for services through the SEBD process numbered 799 and were 42.0% of the registered population. This was an increase of 53 youth, or a 7% increase in the SEBD category over the previous quarter (January 2006-March 2006).

QUEST-eligible youth who received services in the quarter were 38.0% of the population. This proportion of QUEST enrolled youth increased from the previous quarter's slightly lower proportion (36.9%), as well as number (698), of youth. Although the data showed a decline in proportion of the population in the reporting quarter, the pattern of expanding services to QUEST youth continued. QUEST-eligible youth may also be eligible for services through CAMHD because of their educational or juvenile justice status.

Table 6. Diagnostic Distribution of Registered Youth

Any Diagnosis of	N	%
Disruptive Behavior	805	48.4%
Attentional	669	40.2%
Mood	572	34.4%
Miscellaneous	449	27.0%
Anxiety	328	19.7%
Substance-Related	266	16.0%
Adjustment	174	10.5%
Mental Retardation	36	2.2%
Pervasive Developmental	37	2.2%
Multiple Diagnoses	1,190	71.5%
Ave. Number of Diagnoses	1.9	

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 6). The reported percentages may exceed 100% because youth may receive diagnoses in multiple categories.

The top three diagnoses of youth with registered services in the quarter were Disruptive Behavior disorders (48.4%), Attentional disorders (40.2%), and Mood disorders (34.4%), a pattern consistent with last quarter. This quarter saw a slight increase in the number of youth with Attentional disorders, although there continues to be more youth with Disruptive disorders. Miscellaneous diagnoses accounted for 27.0% of youth in the CAMHD population. This category includes individual diagnoses that occur less frequently in the population including cognitive, psychotic, somatic, dissociative, personality, sexual, tic, impulse control, learning and eating disorders.

The majority of youth in the CAMHD registered population have co-occurring, or more than one diagnosis. In the reporting quarter, 71.5% of registered youth had more than one diagnosis, with an average of 1.9 diagnoses per youth. This is a slight decrease from the previous quarter (January 2006-March 2006) when 71.8% had co-occurring disorders. For those with services authorized, the percentage of youth with multiple diagnoses was even higher (76.7%) with an average of 2.2 diagnoses per youth, which means that over three quarters of youth that received services within the CAMHD array in the quarter had co-occurring diagnoses. This continues a long-term pattern of increasing diagnostic comorbidity among youth receiving CAMHD services. The co-occurring diagnoses category includes any DSM-identified disorder whether behavioral, developmental, emotional or substance-related.

In the quarter, youth with substance-related diagnoses represented 16.0% of the registered population, a decrease of .1% from the previous quarter. This statistic may not represent all youth with a substance-related impairment, or the number of youth with substance use identified as a target of intervention. Because diagnostic criteria for substance-related disorders require youth to exhibit a variety of symptoms and impairment, not all youth who use substances or who might benefit from interventions targeting substance use would be diagnosed with a substance-related disorder. Therefore, this statistic, which is drawn from the diagnostic category, is expected to underestimate the total number of youth experiencing a substance-related impairment.

Services

Service utilization information is used throughout CAMHD to assure efficient use and timely access to services. At the case level, service data are constantly reviewed to provide services based on child and family needs, and provision within the least restrictive environment. Tracking of utilization of the services at the aggregate level allows for accurate accounting, and data-driven planning and decision-making.

CAMHD tracks the utilization of services through CAMHMIS for services that are electronically procured. For services that are not electronically procured, information from the Clinical Services database is used to augment the CAMHMIS database to yield the final numbers reported here. CAMHD produces a separate detailed quarterly service utilization report with information regarding statewide utilization of services for all levels of care. As discussed previously, because utilization data are dependent on an accounting of claims adjudicated, it is not possible to present actual utilization for the current reporting quarter (April 2006-June 2006). Therefore, service authorization data are presented here, which closely approximates the actual utilization for the quarter for most levels of care.

Home and community based services continue to account for the majority of services provided to youth. Specifically, 51.5% of youth with services authorized received Intensive In-Home (IIH) services and 13.9% received Multisystemic Therapy (MST). Compared to the previous quarter, the percentage of youth (50.0%) receiving Intensive In-Home services showed an increase, whereas the percentage of youth (14.1%) receiving Multisystemic Therapy services showed a slight decrease.

Table 7. Service Authorization Summary (April 1, 2006-June 30, 2006).

Any Authorization of Services	Monthly Average	Total N	% of Registered	% of Served
Out-of-State	7	7	0.4%	0.7%
Hospital Residential	17	26	1.4%	2.7%
Community High Risk	9	9	0.5%	0.9%
Community Residential	94	127	6.7%	13.0%
Therapeutic Group Home	69	92	4.8%	9.4%
Therapeutic Family Home	129	149	7.8%	15.2%
Respite Home	0	0	0.0%	0.0%
Intensive Day Stabilization	0	0	0.0%	0.0%
Partial Hospitalization	0	0	0.0%	0.0%
Day Treatment	0	0	0.0%	0.0%
Multisystemic Therapy	99	136	7.1%	13.9%
Intensive In-Home	410	504	26.5%	51.5%
Flex	99	155	8.1%	15.8%
Respite	23	27	1.4%	2.8%
Less Intensive	51	124	6.5%	12.7%
Crisis Stabilization	6	14	0.7%	1.4%

Note: Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

The largest group of youth in an out-of-home setting received services in a Community-Based Residential program (13.0%). The percentage of youth receiving these services decreased from the previous quarter (15.0%) and from the same period of last year (15.5%). Along these lines, the use of Hospital-based Residential (HBR) services (2.7% during period) decreased slightly from the previous quarter (2.9%) and decreased considerably from the same period of last year (4.0%). The trend toward increasing utilization of HBR in recent years appears to have been reversed over the last several quarters.

Although the quarter continued to experience the pattern of a decreasing utilization of the most restrictive out-of-home services, the utilization of Therapeutic Family Homes (15.2%) also decreased slightly this quarter over the previous quarter (15.4%), but increased over the same period of last year (14.9%). Utilization of Therapeutic Group Homes (9.4%) fluctuated a bit in earlier quarters of the fiscal year (the same utilization as the previous quarter 9.4%) and showed a slight decrease from a year ago (9.2%).

In the reporting period, Ancillary Services paid through Flex funding were provided for 15.8% of registered youth, which was an increase from last quarter's utilization of these services for 14.3% of the registered population. Ancillary Services are designed to maintain youth in their homes (prevent out-of-home placements) through supports that are not found in the regular array of services, or to pay for specialized services. The largest use of Flex funding was to pay for travel cost for youth in out of home settings.

Respite Home services had no youth accessing this service in the current quarter, as well as the previous quarter. The last time these services were utilized was during the first quarter of fiscal year 2006, when it was accessed by 0.6% of youth. On an annualized basis, utilization has increased somewhat, but overall utilization of this service remains low. In CAMHD's new RFP, payment for Respite Homes was been restructured to remove any access obstacles. Respite Homes were designed to support caregivers' capacities and prevent potential out-of-home placements. The consistently low utilization of this service indicates either little need for this service or that potential barriers exist to accessing this service. One identified obstacle had been the payment structure for these homes. Therefore, this was addressed in the new RFP.

No utilization of Intensive Day Stabilization Services continued. Intensive Day Stabilization has been replaced with Partial Hospitalization in the new RFP.

Respite services are a different level of care than Respite Homes in that they do not need to be provided by a Therapeutic Foster Home provider and are more flexible in nature. Utilization of Respite services decreased with 2.8% of youth accessing these services in the quarter as opposed to 3.3% last quarter.

Cost

CAMHD uses several sources of information about expenditures and the cost of services to understand cost across all services delivered. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). Because cost data are available the quarter following the adjudication of all claims, the cost data discussed below represents expenditures for services provided during the third quarter of fiscal year 2006 (January 2006-March 2006). Unit cost information may not be available in CAMHMIS for certain types of services or payment arrangements (e.g., cost reimbursement contracts, emergency services). For these services, wherever possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and Family Guidance Centers.

Detailed allocation of cost information for the reporting quarter by each level of care is presented in Table 8. Out-of-Home residential treatment services in Hawaii accounted for 80.2% of service expenditures, which is 1.5% below the previous quarter's percentage of cost. Youth in Out-of-State treatment settings accounted for 1.6% of total expenditures, which is 0.2% above the previous reporting quarter's (October 2005-December 2005) proportion of cost.

Table 8. Cost of Services (January 2006-March 2006)

Any Receipt of Services	Total Cost ($)	Cost per Youth ($)[a]	Cost per LOC ($)[b]	Cost per LOC per Youth ($)[b]	% of LOC Total ($)[b]
Out-of-State	157,696	26,283	150,949	25,158	1.6%
Hospital Residential	1,066,813	41,031	780,560	30,022	8.2%
Community High Risk	419,886	52,486	408,870	51,109	4.3%
Community Residential	3,451,174	24,304	2,929,063	20,627	30.9%
Therapeutic Group Home	2,214,864	24,886	1,579,307	17,745	16.7%
Therapeutic Family Home	2,343,046	16,271	1,899,991	13,194	20.1%
Respite Home	0	0	0	0	0.0%
Intensive Day Stabilization	0	0	0	0	0.0%
Partial Hospitalization	0	0	0	0	0.0%
Day Treatment	0	0	0	0	0.0%
Multisystemic Therapy	724,139	5,247	420,988	3,051	4.4%
Intensive In-Home	1,851,231	4,051	954,562	2,089	10.1%
Flex	3,276,432	23,073	209,968	1,479	2.2%
Respite	211,551	5,718	51,298	1,386	0.5%
Less Intensive	60,355	15,089	9,812	2,453	0.1%
Crisis Stabilization	152,748	7,637	73,838	3,692	0.8%

Note: a Cost per youth represents the total cost for all services during the period allocated to level of care based on duplicated youth counts. Thus, the average out-of-state cost per youth includes total expenditures for youth who received any out-of-state service. If youth received multiple services, the total expenditures for that youth are represented at multiple levels of care (duplicated US$). b Cost per LOC represents the unduplicated cost (US$) for services at the specified level of care. c Due to a billing error no accepted records were available for Hospital Residential services during FY2005 Q1. Therefore, data from provider census reports were used for this period.

The number of youth receiving Hospital-based Residential services continued to decrease. In contrast with the increased census, the current quarter witnessed a decrease in the average length of service in the Hospital setting. Accordingly, the total cost of services for youth who received Hospital Residential services during the quarter decreased from $1,167,637 to $1,066,813. The cost for Hospital-based Residential services also decreased ($780,560 compared to $970,401 in the prior quarter). In addition, the cost per youth decreased from $41,701 to $41,031 for total costs and from $34,657 to $30,022 for Hospital Residential costs only.

Along with the decrease in authorization of Community-Based Residential (CBR) during the third quarter of fiscal year 2006, utilization of this service has been decreasing. Accordingly, the cost of CBR services decreased in the reporting quarter (i.e., third quarter of fiscal year 2006 compared to second quarter of fiscal year 2006) both in terms of total dollars and average cost per youth. Youth with high-risk sexualized behaviors who received treatment services in a Community High-Risk Program at some point during the quarter continued to have the highest total cost per youth ($51,109 per youth), which also increased from the previous quarter. For other types of residential treatment, the lowest cost per youth was for those who received services in Therapeutic Foster Homes ($13,194 per youth), which has been consistent over time, and stands out as the most cost-effective residential service in addition to being the least-restrictive.

In-Home (Intensive In-Home and MST) and Less Intensive services accounted for 14.6% of the unduplicated cost of services. This is a slight increase from the last reporting quarter (October 2005-December 2005) percentage of total costs for those categories, and this has been a trend over the past six quarters, corresponding to less utilization of residential services. Youth receiving Intensive In-Home services at some point during the quarter cost an average of $4,051 per youth ($2,089 of which was for Intensive In-Home service expenditures only), which continues to be significantly less than the cost per youth in any residential program.

For those youth who received Ancillary Services, average cost per youth for the Flex funded services was only $1,479 per month and the average cost for all services to those youth who received one or more Ancillary services was $23,073 per youth. The average cost per youth for a child receiving a Flex-funded service at some point during the quarter also includes their service costs in other levels of care, and may include residential services. The high average total cost per youth for these services suggest that youth in out-of home placements account for a high percentage of youth receiving a Flex-funded service. A high proportion of Flex-funded services are travel-related including family visits when placement is off-island. As previously reported, CAMHD is in the process of adding travel costs to the MOA with the Med-QUEST Division for QUEST-eligible youth, allowing the State to recoup federal funds for a portion of this cost. This agreement will apply retrospectively.

Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through the Department of Accounting and General Service's Financial Accounting Management Information System (FAMIS). For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for the central and branch offices that are reported in the Performance Measures section. However, it is important to note that FAMIS tracks payments and encumbrances when they are processed at the Departmental level. Due to the time lag between service provision and payment, the CAMHMIS and FAMIS systems do not track the same dollars within any

given period. Therefore, estimates provided here are used for general guidance, and detailed financial analysis is conducted by CAMHD Administrative Services.

Recent developments to the chart of accounts in the financial accounting system allows for more specific coding of purchases into specific service categories. Therefore, as the system continues to develop and new reporting functions are programmed, comprehensive financial reports providing detailed service expenditures should be available from FAMIS. This should lead to reduced burden for manual reporting and increase the capacity of the fiscal section to perform timely and thorough financial analysis.

Services for Youth With Developmental Disabilities

CAMHD entered into a Memorandum of Agreement (MOA) with the Developmental Disabilities Division (DDD) of the Department of Health in July 2002 for the purposes of serving the needs of those youths with mental retardation and/or developmental disabilities and/or autism (target population) who had previously received respite and out-of-home services through CAMHD. The MOA transferred funding and personnel to DDD so that these children could receive appropriate individualized supports consistent with national best practices in developmental disabilities.

The table below summarizes the expenditure of dollars for respite services provided by DDD from July 1, 2002 through June 30, 2006:

Table 9. Expenditures to Date for Respite by Island

Island	# Youth Served	% of Total Youth	Total Cost Per Island	% of Total Dollars Expended	Average Cost Per Youth
Oahu	73	55%	$148,303.93	44%	$2,031.56
Hawaii	34	26%	$89,714.00	27%	$2,638.65
Kauai	11	8%	$61,644.50	18%	$5,604.05
Maui	14	11%	$37,358.00	11%	$2,668.43
Total Youth	132	Total Dollars Expended (July 2002 - June 30, 2006)			$337,020.43

Note: There are currently no reports of respite expenditures for the period April 2006 through June 2006.

Although the MOA ended on June 30, 2004, DDD continues to provide case management, individual support, respite, and out-of-home support services for the identified target population. DDD utilized the respite monies transferred from CAMHD as part of its state match for its HCBS-DD/MR Medicaid waiver program, thereby maximizing state funds and qualifying DDD services for federal reimbursement.

Respite Services

The target population received at least one support service from the DDD service system. For this current quarter, April 1, 2006 through June 30, 2006, the following table shows the utilization of various DDD funded services (short term) that families accessed to meet their needs:

Table 10. Other Service Options Utilized by Respite Recipients

DDD Funded Services	# of Users
Purchase of Services - Partnerships in Community Living	9
DOH - DDD Respite	29
Family Support Services Program	10

Since July 2002, DDD has admitted 62 of the target population into the Home and Community Based Services – DD/MR (HCBS-DD/MR) Medicaid waiver program. There were no waiver admissions or discharges in the fourth quarter of FY '06.

Based on the latest expenditure information available for the period January 1, 2006 through March 31, 2006, the following table shows the number of clients in the target population and total dollars spent for two of the HCBS-DD/MR Medicaid waiver services, respite and personal assistance.

Table 11. Waiver Service Options Utilized by Respite Recipients

Waiver Services (January 1, 2006 – March 31, 2006)	# of Clients	Total $
Respite	4	$15,468.00
Personal Assistance	40	$459,850.00

Note: Amounts are rounded off to the nearest dollar.

Residential Services

The Individual Community Residential Support (ICRS) contract ended on June 30, 2006. DDD added Residential Habilitation services (Res/Hab Level 4) to the array of services provided under the HCBS-DD/MR waiver program on July 1, 2006. Currently, Residential Habilitation services are provided in the special treatment facility for two youths. One youth transitioned into a DDD Adult Foster Home in the 4th quarter.

All but one individual of the thirteen youths that originally received ICRS services have been admitted to the HCBS-DD/MR waiver program. This one individual remains in a psychiatric facility, and, although discharge has been recommended, transition to community-based services has not occurred.

Performance Measures

CAMHD performance measures to demonstrate adequacy of services, results, infrastructure, and key practice initiatives are found in this section. If baseline performance falls below the established goals, CAMHD systematically examines the trends and any barriers, and develops strategies to achieve each goal. A stable pattern of results (i.e., a flat line) indicates that CAMHD is sustaining performance at baseline levels. A line that exceeds its benchmark indicates that CAMHD has surpassed its performance goals.

Performance measures linked to "measures of sustainability" are noted by an asterisk (*).

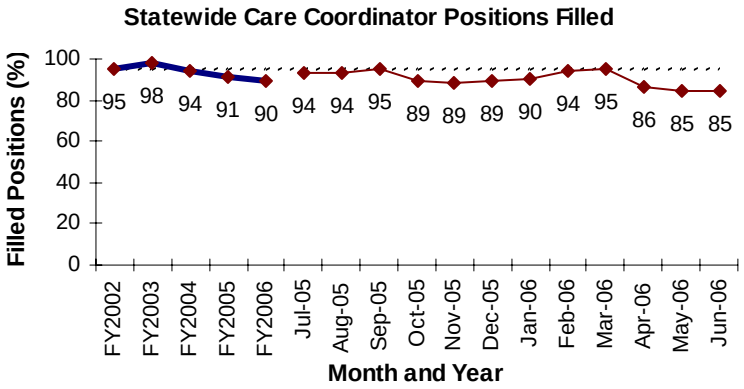
CAMHD will maintain sufficient personnel to serve the eligible population

Goal:

⇨ **95% of mental health care coordinator positions are filled.***

The data for this measure have been adjusted beginning this quarter to reflect the actual number of filled care coordinator positions, and does not include positions filled by temporary employees (89-day hires). CAMHD's quality management committee reviewed the reporting methodology and concluded that filling positions with 89-day hires does not adequately assure that sufficient, trained personnel are providing case management services. They further concluded that this measure should appropriately reflect the stability of the case management function in CAMHD. Going forward, the data for this performance measure will reflect only positions filled by civil service or exempt employees, and not employees on an 89-day appointment.

Over the reporting period, CAMHD had an average of 85% of care coordinator positions statewide filled, which was 10% below the performance goal of 95% filled positions. This quarter's result reflects the tenth consecutive quarter the performance goal was not met.



The length of time it takes to fill care coordinator positions within the State personnel hiring process continues to be a significant factor in meeting this performance goal. The average length of time all care coordinator positions have been under recruitment statewide is 198 days.
The process for filling civil service positions in the state involves receiving a list of qualified candidates from the Department of Human Resources Development (DHRD). Lists, when received, often have few

candidates. Coupled with a shortage of qualified health care professionals in general in Hawaii, particularly in rural areas, the process has not resulted in the timely hiring of qualified care coordinators for the 11.5 current vacancies.

The percentage of filled Care Coordinator positions over the quarter for each Family Guidance Center is displayed below.

COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KAUAI
96%	90%	68%	88%	82%	80%	100%

As seen above only Central and Kauai FGCs had sufficient care coordinators and met the performance goal. Each of the centers that did not meet the goal experienced one to four vacancies during the quarter. The inability to fill positions impacts caseloads, and likely access to services as it is hypothesized that the rate of discharges has increased as vacancies have risen (an analysis of this is underway).

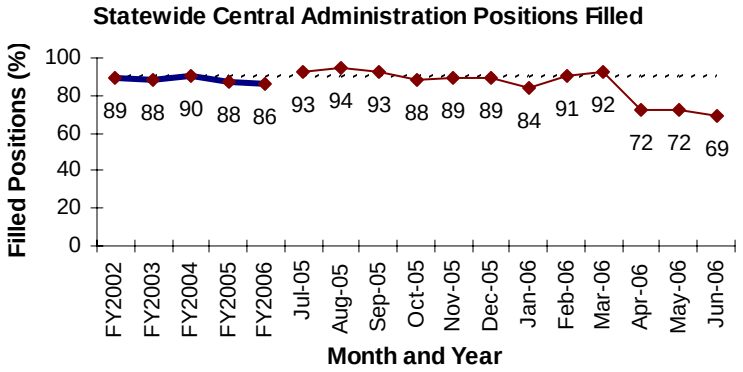
As a strategy to improve human resource management, Branch Chiefs receive weekly briefings from the CAMHD personnel office to facilitate communication and understanding when hiring obstacles are encountered. CAMHD will need policy level interventions should the ability to have a stable trained workforce continue to erode.

Goal:

⇨ **90% of central administration positions are filled.***

Like the care coordinator positions filled measure, this measure is adjusted beginning this quarter to exclude any temporary hires.

The performance target did not meet the desired performance with an average of 71% of central administration positions filled over the quarter.



This is a decrease from last quarter's performance of 89% and represents the third consecutive quarter CAMHD has missed the performance goal. At the end of the quarter, 19 of the 61 positions in the Central Administrative Offices were vacant for a 31% vacancy rate. Central Office staff perform monitoring, billing, information systems, contracting, training and other key service system functions. This is the largest vacancy rate to date for CAMHD's infrastructure.

The average number of days vacant positions in the central administrative office have been under recruitment (as of July 20, 2006) is 217 days. These positions are about half civil service and half exempt. Additionally, higher-level clinical positions have been difficult to fill because of the existing process required to fill above the established position salary.

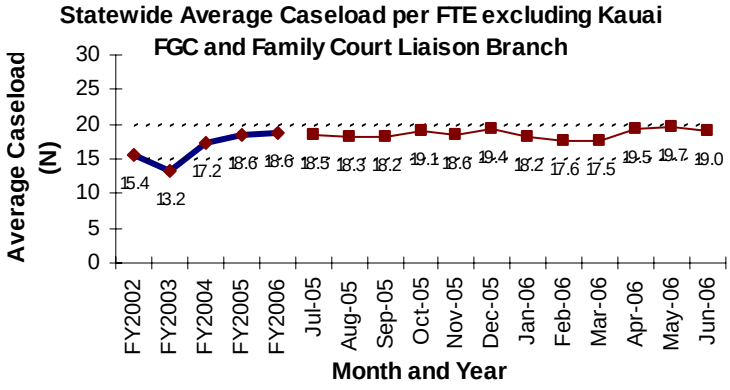
Recruitment and retention of employees is further impacted by the Civil Service Replacement project where all exempt positions will be replaced by civil service positions. The civil service requirements will impact current employees in a number of ways from inability to meet length of time in service requirements, to lack of crosswalk to current salaries. These factors add to the difficulty in attracting new employees and retaining current staff in a job market that is already strained in Hawaii.

Vacant positions are distributed throughout central administration, with all offices experiencing some vacancies, including the MIS system, billing positions (including a position to develop the third-party billing system), and the program monitoring area. The inability to fill the Practice Development Supervisor, vacant since February 2006, has resulted in less consultation and training for the service system, and a strain on system leadership for several evidence-based interventions being brought on line.

Goal:

⇨ **Average mental health care coordinator caseloads are in the range of 15 - 20 youth per full time care coordinator.**

The statewide average caseload for the fourth quarter was within the target range at 19.4 youth per full time care coordinator equivalent (FTE), which meets the performance goal for the measure. However, the statewide average is at the extreme high end of the range, and caseloads are at their highest level since performance on this measure began tracking in FY2002. It is expected that care coordinator caseloads consistently fall in the range of 15 to 20 youth per full time care coordinator in order to provide quality intensive case management services. Average caseloads have been in the high end of the range statewide for nearly two years.



The average caseload performance target was not met for Leeward Oahu and Hawaii FGCs, where caseloads were above the expected range. Maui, Windward, and Honolulu are all at or nearing the upper end of the

expected caseloads. It should be noted that Leeward and Hawaii are the two communities that are impacted by socio-economic variable and demographics that include high multi-agency involvement for youth, making case management often more of a challenge.

Average Caseloads by Family Guidance Center

	COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC
4th Quarter Average	16	21	20	18	19	22

The calculation of average excludes Kauai, which serves both high-end and low-end youth through the Mokihana project, and therefore have higher caseloads. Family Court Liaison Branch is also excluded because staff provide direct services to youth while at Detention Home or Hawaii Youth Correctional Facility, the majority of which are receiving care coordination from another Family Guidance Center.

CAMHD will maintain sufficient fiscal allocation to sustain service delivery and system oversight

Goal:

⇨ Sustain within quarterly budget allocation.

CAMHD met the goal for sustaining within its budget. The reporting quarter for this performance measure is January 2006-March 2006, which allowed for closing of the contracted agency billing cycle. Expenditures for Branch and Services totals were below budget ($325,000 and $247,000 respectively). The Central Office total was also below budget by $159,000. Total variance from the budget for the reporting quarter was under projection by $499,000. Sufficient funds were encumbered for all expected service costs.

Variance from Budget (in $1,000's)

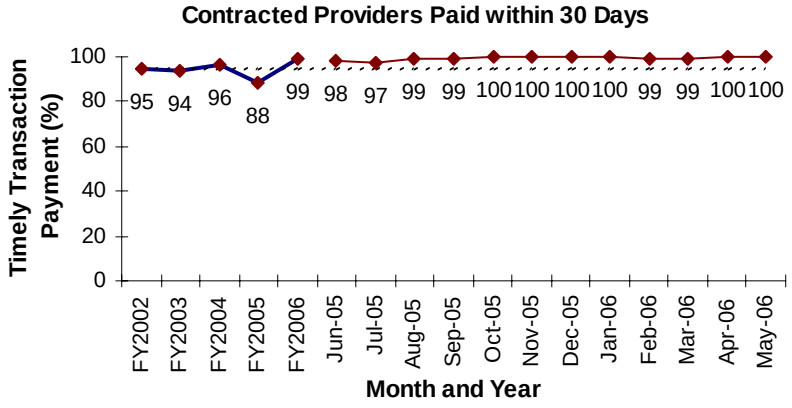
	FY 2002 Average	FY 2003 Average	FY 2004 Average	FY2005 Average	FY2006 Average	2005.1	2005.2	2005.3	2005.4	2006.1	2006.2	2006.3
Branch Total	$164	-$150	$20	-$242	-$300	$20	-$337	-$338	-$312	-$159	-$416	-$325
Services Total	$798	-$4,175	-$1,849	-$102	-$234	-$2	-$203	-$155	-$49	-$105	-$351	-$247
Central Office Total	-$189	-$388	-$314	$68	$36	-$15	-$30	$86	$231	$148	$118	-$159
Grand Total	$773	-$4,713	-$2,142	-$276	-$499	$4	-$571	-$407	-$129	-$116	-$648	-$732

CAMHD will maintain timely payment to provider agencies

Goal:

⇨ 95% of contracted providers are paid within 30 days.

This quarter, 100% of contractors were paid within the 30-day window over the quarter. This is a slight increase over last quarter's average of 99.5% of contracted providers paid within 30 days, and meets targeted performance for this measure. The performance goal has been met consistently since May 2005 and reflects strong fiscal practices in CAMHD.



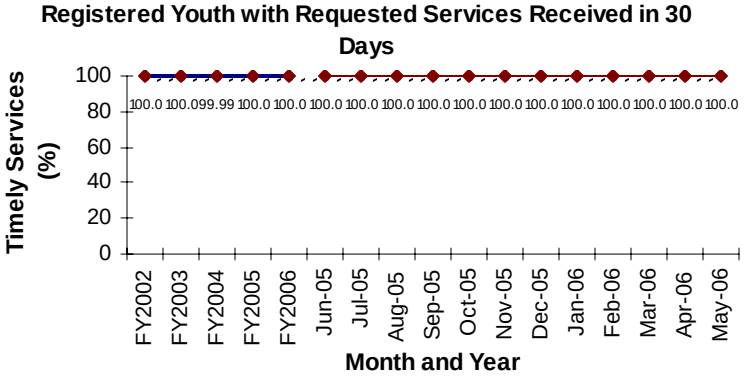
As is standard for this report, the quarter's data is available for the first two months of the quarter (April and May 2006) and includes March 2006.

CAMHD will provide timely access to a full array of community-based services

Goal:

⇨ **98% of youth receive services within thirty days of request.***

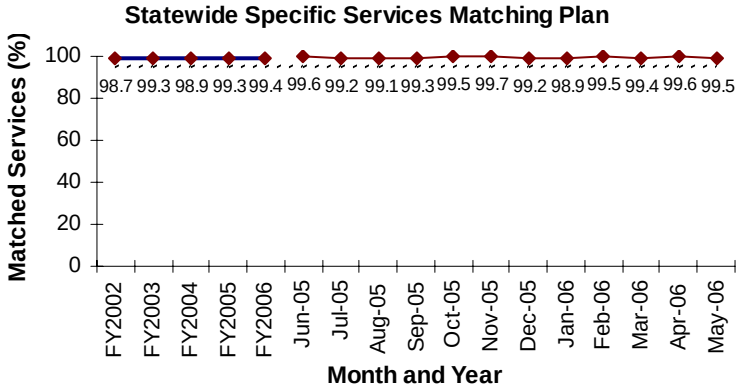
The goal was met for the quarter with 100% of youth provided timely access to services. Data are for the first and second month of the reporting quarter (April and May 2006) as third month data are not available at the time of publication. March 2006 data are included in the average for the quarter. This measure has consistently met the goal since it began to be tracked in fiscal year 2002.



Goal:

⇨ **95% of youth receive the specific services identified by the educational team plan.***

CAMHD continued to demonstrate strong performance on this measure. Over the quarter, 99.6% of youth received the specific services identified by their team plan. Data are for the first and second month of the reporting quarter (April and May 2006) as third month data are not available at the time of publication. March 2006 data are included in the average for the quarter. This measure includes SEBD youth who do not have an educational plan.



In the quarter, service mismatches occurred in nine complexes versus twelve in the previous quarter. Kapolei and Kailua Complexes had three and two youth respectively receiving mismatched services. The remaining complexes each experienced one mismatch. Campbell and Pearl City had continuing mismatches from the previous quarter. The regional FGCs and

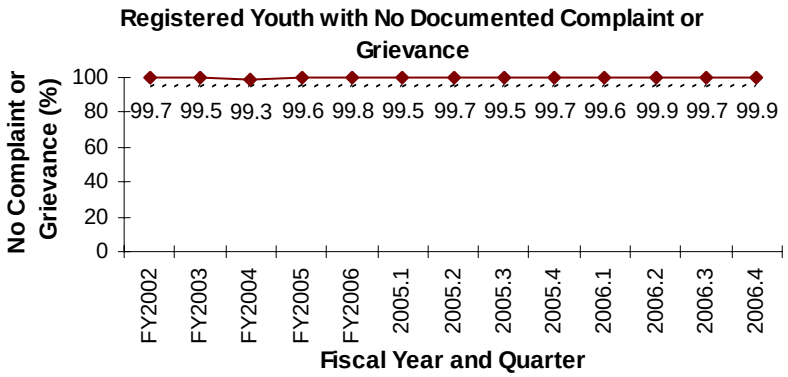
the Utilization Management Committee regularly conduct analyses of the mismatches. Recommendations for service expansion have been collected and have been integrated where appropriate into the RFP for the updated service array.

CAMHD will timely and effectively respond to stakeholders' concerns

Goal:

⇨ **95% of youth served have no documented complaint received.***

99.9% of youth served in the quarter had no documented complaint received, which exceeds the performance goal. The target was met across all Family Guidance Centers. Performance on this goal has been sustained since it was established in June 2001.

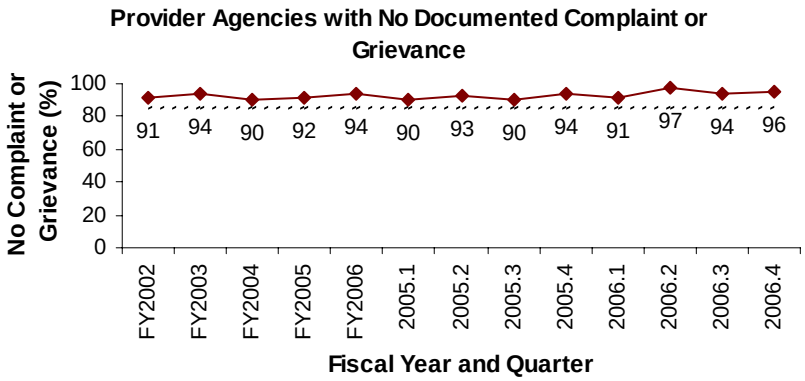


In the quarter, there was a complaint received from 1 youth (or someone complaining on their behalf) representing 1 complex statewide as compared to 4 youth with documented complaints representing 3 complexes last quarter. There was one complaint for the Kaimuki Complex, although services were being provided by the Windward Family Guidance Center. The Kaimuki complex did not have any complaints the previous reporting quarter.

Goal:

⇨ **85% of provider agencies have no documented complaint received.**

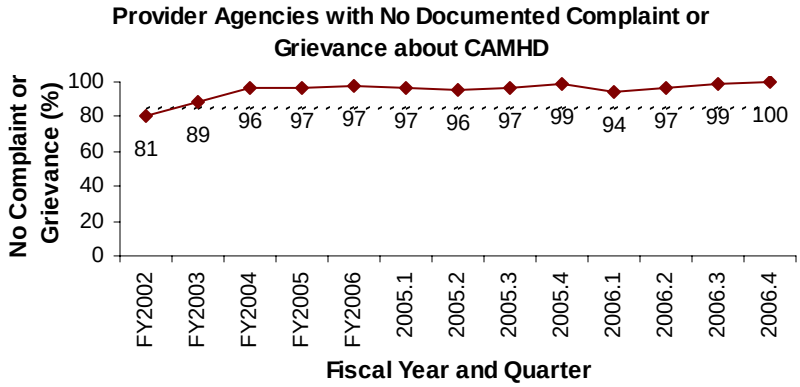
96% of provider agencies had no documented complaint registered about their services, which met the performance goal. The performance target for this measure has been consistently met since the second quarter of fiscal year 2004. It is recommended that the benchmark for this measure be adjusted upward to reflect the trend.



Goal:

⇨ **85% of provider agencies will have no documented complaint about CAMHD performance.***

In the quarter, 100% of agencies in the CAMHD provider network had no documented complaint or grievance about CAMHD. This measure has consistently met the performance goal since the beginning of FY 2003. Again, it appears that an adjustment to the performance goal is in order.



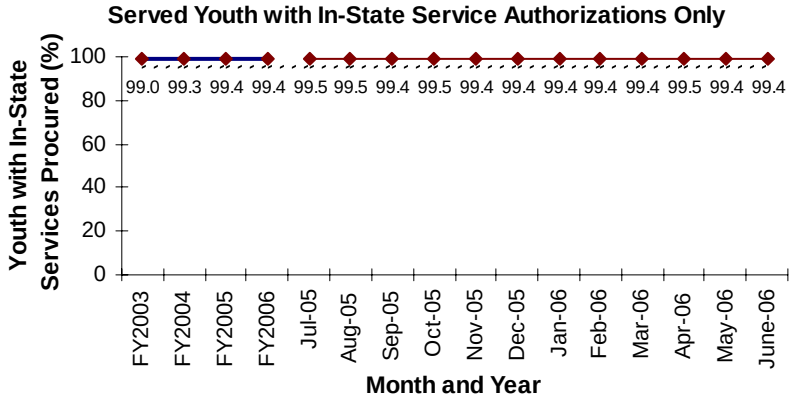
Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting

Goal:

⇨ **95% of youth receive treatment within the State of Hawaii.***

In the quarter, an average of 99.4% of CAMHD registered youth served received treatment within the State, which exceeds the goal. Six youth in April and May and seven youth in June received services in out-of state treatment settings.

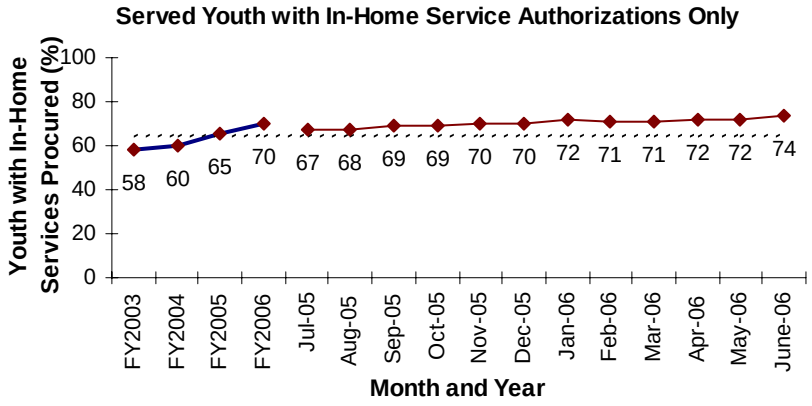
These data represent only youth registered with CAMHD who were in out-of-state treatment settings in the reporting quarter, and does not represent youth who may have this service paid for by other State agencies.



Goal:

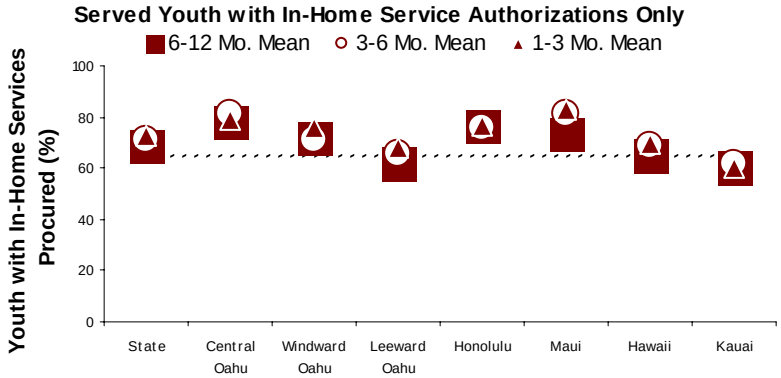
⇨ **65% of youth are able to receive treatment while living in their home.**

An average of 73% of youth were served in their home communities during the quarter, which is 8% above the performance goal. This quarter's performance was above last quarter's average of 71% of youth served in their homes. The in-home services performance measure is calculated at the percent of youth who did not receive an out-of-home service authorization during the quarter and either received an in-home service authorization or were enrolled in the CAMHD Support for Emotional and Behavioral Development (SEBD) program divided by the total number of youth with a service authorization or SEBD enrollment during the period.



The pattern of improved performance on this measure reflects both the expansion of the SEBD program and increased use of home and community services coinciding with decreased utilization of residential services over the past year. A recommendation regarding a new performance goal for this measure will likely be formulated after watching this trend for several more quarters, particularly within the context of the introduction of new services through the new service contracts.

There was variable performance across the Family Guidance Centers in meeting the goal as can be seen below, however performance appeared consistent within their own historical patterns.



The goal was met for Central Oahu (79% served in-home), Windward Oahu (75.7% served in-home), Leeward Oahu (68.1% served in-home), Honolulu (76.9% served in-home), Maui (82.8% served in-home), and Hawaii (69.2% served in-home).

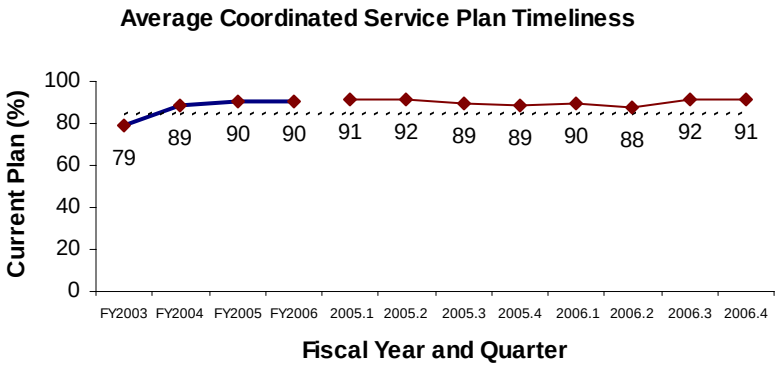
Serving youth in their homes and home communities when such services are likely to be effective continues to be a core value for CAMHD. Both the Leeward Oahu and Hawaii Family Guidance centers have historically had higher out-of-home service rates, however the proportion of youth showing positive outcomes from these centers are comparable to other centers in the state.

CAMHD will consistently implement an individualized, child and family centered planning process

Goal:

⇨ **85% of youth have a current Coordinated Service Plan (CSP).***

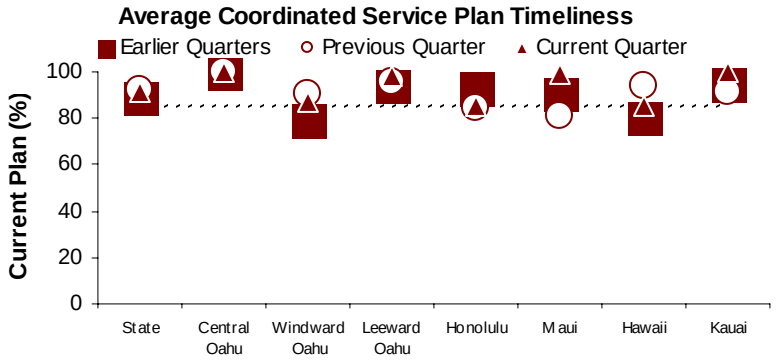
CAMHD's performance in this measure met the performance goal for the reporting quarter with 91% of youth across the state having a current CSP. The average for the year is 90%. The performance has remained stable statewide and the goal has been met for the past three years.



Note: This data includes youth who were newly admitted to CAMHD who have not yet had a CSP developed, but does not include youth awaiting an assessment for determination of SEBD.

"Current" is defined as having been established or reviewed with the CSP team within the past six months. Quarterly reviews of timeliness are conducted to assess for current CSPs. Registered youth receive an initial Coordinated Service Plan within 30 days of determination of eligibility.

Trend data for each FGC are displayed below. The goal was met in all of the FGCs. Hawaii FGC's improvement strategies of increasing supervision and filling a vacant Mental Health Supervisor position has had an impact in the performance of this indicator over time, but performance declined in the quarter. Kauai FGC, which had seen decreases in timeliness over previous quarters, showed an increase in timeliness in the fourth quarter.

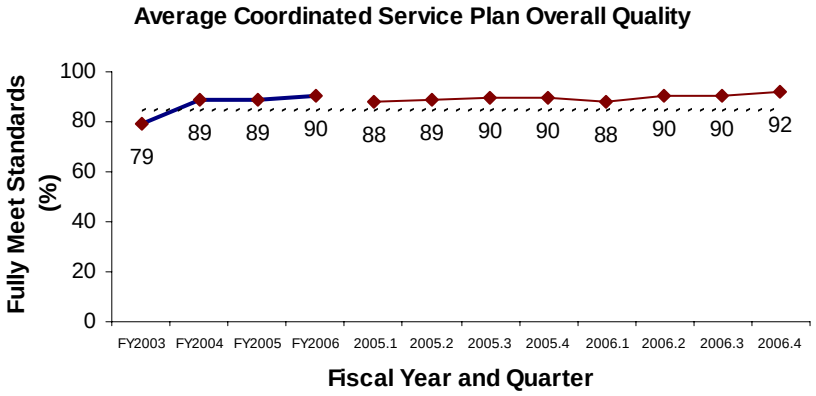


In the previous quarter, Maui FGC experienced a decline in performance. This quarter, the FGC rebounded significantly, and almost met the 100% mark.

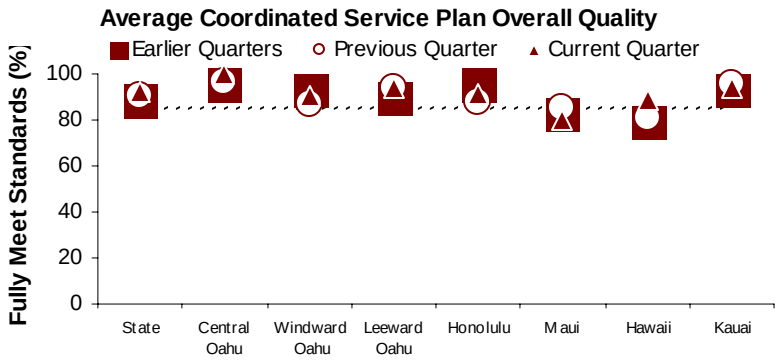
Goal:

⇨ **85% of Coordinated Service Plan review indicators meet quality standards.***

The goal for this measure was met statewide in the reporting quarter with 92% of CSPs sampled meeting overall standards for quality. The goal has been met for the past three years at the statewide level.



CSPs are reviewed quarterly by the FGCs to determine if they meet the standards for effective plans. In order for a CSP to be deemed as acceptable overall, there must be evidence that the plan is meeting key quality indicators including stakeholder involvement, clear understanding of what the child needs, individualization of strategies, identification of informal supports, long-term view, plan accountability, use of evidence-based interventions, crisis plans and several other key measures.



As seen in the chart above, the goal was met or exceeded by all FGCs with the exception of Maui FGC, which experienced a dip in performance and did not meet the quality goal. Hawaii FGC, which fell short of the goal the previous quarter, rebounded this quarter to meet the standard for the first time since the second quarter of fiscal year 2005.

There will be a statewide community-based infrastructure to ensure quality service delivery in all communities

Goal:

⇨ **85% of performance indicators are met for each Family Guidance Center.**

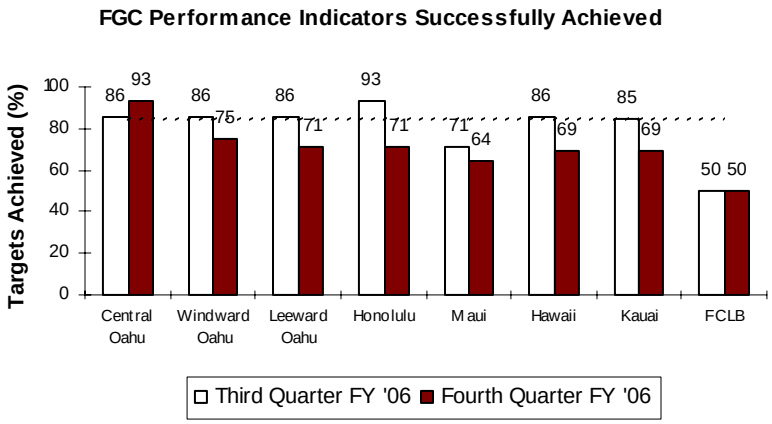
Only one of the eight Family Guidance Centers, Central FGC, met the performance goal this quarter. Last quarter six FGCs met their goals.

Family Guidance Center performance is evaluated based on the percentage of performance targets that are met or exceeded in the quarter. Performance targets are comprised of the relevant measures presented in this report, and include individual FGC performance on: personnel measures, expenditures within budget, grievances, access to services (service gaps/mismatches), least restrictive environment (served in-home), timeliness and quality of coordinated service plans, performance on internal reviews, improvements in child status, and family satisfaction. Improvements were seen in the quarter in many of these indicators.

Across all branches, 70.3% of all goals were met in the quarter, compared to 80.4% in the last quarter, and 74.6% over the same period last year.

Central showed improvement over the previous quarter and over the same period of last year. Windward, Leeward, Honolulu, Maui, Hawaii, and Kauai FGCs and the Family Court Liaison Branch (FCLB) did not meet performance goals. Maui, Hawaii, and Kauai showed improvement over the same period last year. Conversely, Windward, Honolulu, and FCLB showed declines, whereas Leeward remained stable.

Due to its unique configuration, the FCLB is only evaluated for the two indicators of expenditures within budget and percent of youth showing improvement on the CAFAS or ASEBA. Therefore these results tend to be highly variable and are not directly comparable to other branches.



The branches did well on indicators of:

- timely access to services,
- providing services identified by the educational team plan,
- documented complaints from consumers,
- serving youth in the State,
- timeliness of Coordinated Service Plans, and
- maintaining acceptable scoring on Internal Reviews.

One or two branches did not meet goals for:

- average caseloads,
- maintaining within budget,
- serving youth while they are living at home,
- quality of Coordinated Service Plans,
- youth showing improvements as measured by the CAFAS or ASEBA, and
- completing the CAFAS or ASEBA.

Roughly half the branches did not meet goals for:

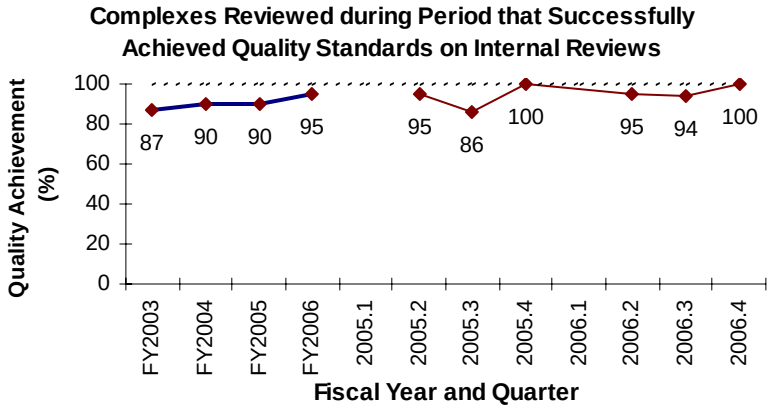
- filling care coordinator positions,
- youth with acceptable child well-being in Internal Reviews,
- family satisfaction, and
- service system satisfaction.

Performance goals not met by a Family Guidance Center are addressed through specific improvement strategies developed by the FGC internal quality assurance committee, and reported up through the CAMHD Performance Improvement Steering Committee. Each FGC management team tracks the implementation of their improvement strategies.

Goal:

⇨ **100% of complexes will maintain acceptable scoring on internal reviews.***

Complex internal reviews for the school year continued in the fourth quarter. Of the two complexes reviewed, both met the system performance goal and one met the goal for child status. This result meets the performance goal for the quarter. Overall for the year, 95% of complexes achieved the goal for acceptable system performance. Acceptable scoring continues to be defined as achieving acceptable system performance and child status for 85% of cases reviewed. The performance target is for 100% of complexes to meet the goal for acceptable system performance and child status.

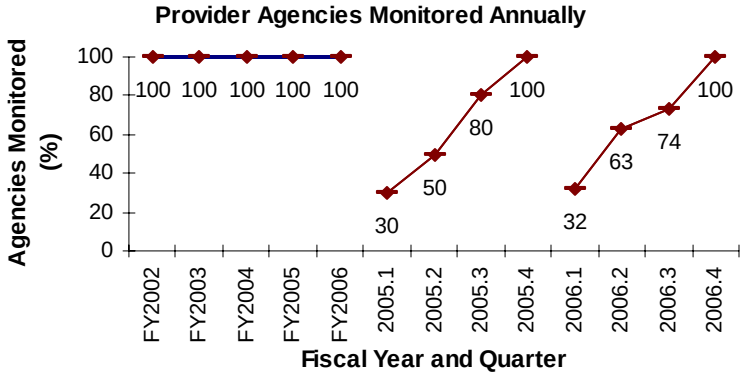


Mental Health Services will be provided by an array of quality provider agencies

Goal:

⇨ **100% of provider agencies are monitored annually.**

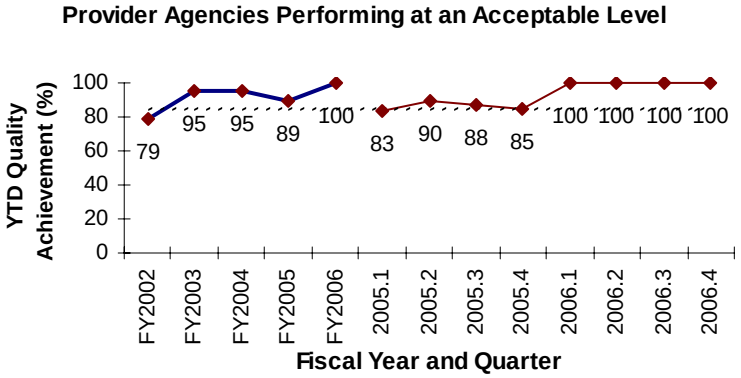
The CAMHD Performance Management Section conducts comprehensive monitoring of all agencies contracted to provide mental health services. In the fiscal year, 100% of all agencies contracted to provide direct mental health services were monitored as scheduled, which met the targeted goal. Five agencies, representing eleven contracts and five levels of care were monitored in the fourth quarter.



Goal:

⇨ **85% of provider agencies are rated as performing at an acceptable level.**

At least annually, provider agencies are reviewed across multiple dimensions of quality and effective practices. In the reporting quarter, 100% of the provider agencies reviewed in the quarter were determined to be performing at an acceptable level, which met the performance goal for this measure. Because monitoring occurs over an annual season, the annual indicator is more reliable than the quarterly indicator.

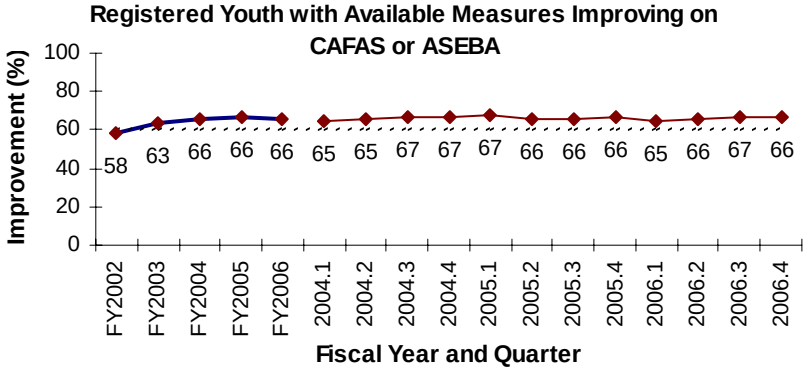


CAMHD will demonstrate improvements in child status

Goal:

⇨ **60% of youth sampled show improvement in functioning since entering CAMHD as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA).***

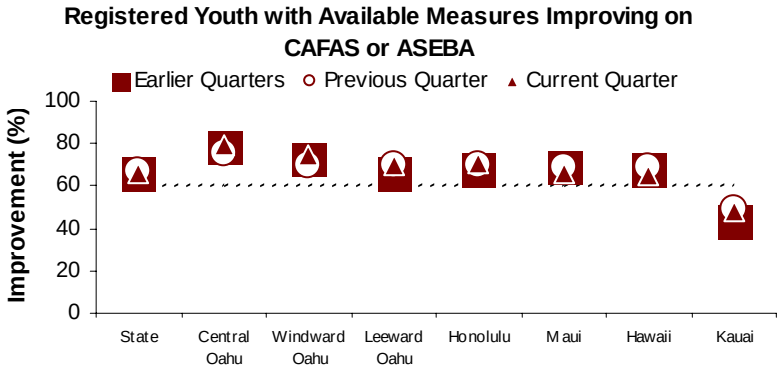
To monitor performance of CAMHD's goal of improving the functioning, competence and behavioral health of youth, care coordinators are required to submit the CAFAS and ASEBA for each youth. The performance goal is measured as the percentage of youth sampled who show improvements since entering CAMHD services and is set at 60%.



In the reporting quarter, for youth with data for these measures, 66% were showing improvements since entering the CAMHD system, which exceeds the performance goal. This indicator had demonstrated improvements

from fiscal year 2002 to 2004, but has settled on a plateau of approximately two-thirds of youth showing improvement at any given point in time. The benchmark for this measure should be adjusted.

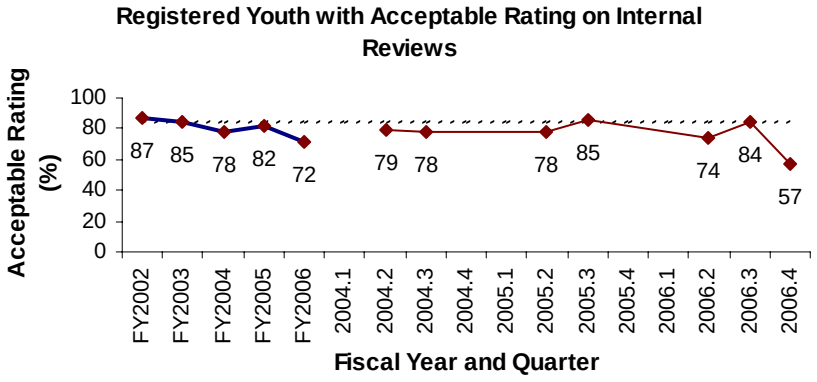
Most branches are performing near the state average with the exception of Kauai, which historically has performed below the average. Kauai's population differs from the other branches due to the Mokihana project, so the branch-to-branch results are not directly comparable. Maui and the Big Island, which had been performing well above the state average, experienced a slight dip in performance this quarter.



Goal:

⇨ **85% of those with case-based reviews show acceptable child status.**

Of youth receiving care coordination and services through CAMHD, 57% were found to be doing acceptably well on measures of child well-being as measured through Internal Reviews. Child status was a concern for several youth reviewed in the Hawaii and Windward Oahu service areas. Systematic review of all youth who have unacceptable child status is now conducted by the Family Guidance Centers through a specific review protocol.



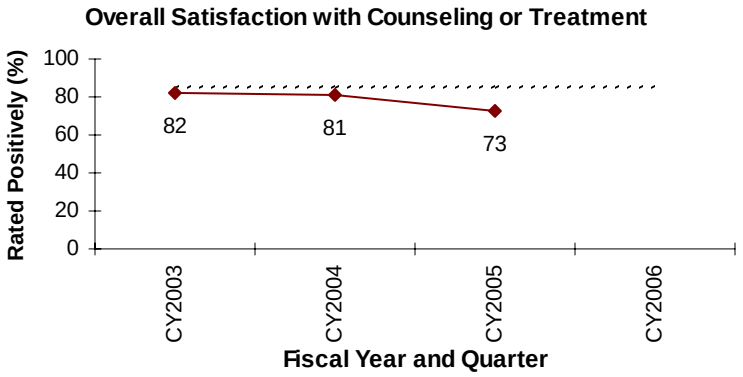
Families will be engaged as partners in the planning process

Goal:

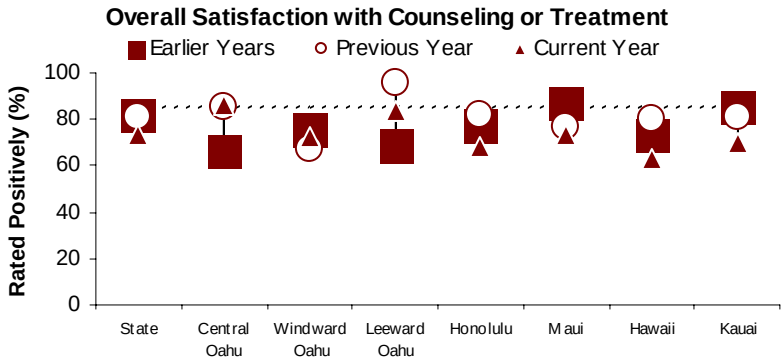
⇨ **85% of families surveyed report satisfaction with CAMHD services.**

CAMHD has historically conducted an annual consumer survey in the spring of each year. Health Services Advisory Group, under contract with the Med-QUEST Division, now conducts a satisfaction survey for the QUEST-enrolled CAMHD population, and CAMHD will conduct the same survey with the remainder of the registered population. The comprehensive report of this year's results can be found on the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/library/pdf/rpteval/cs/cs007.pdf.

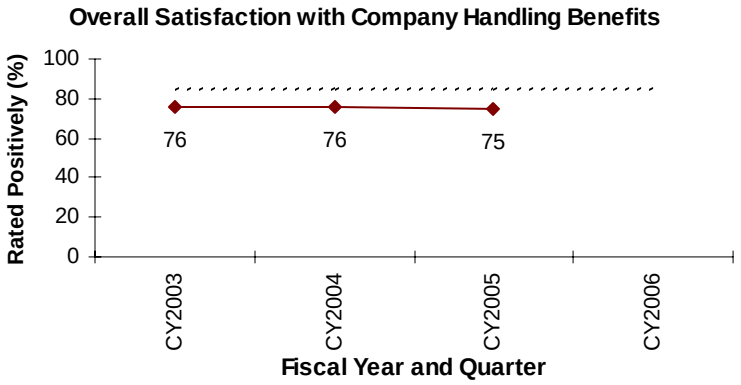
Results regarding two aspects of overall satisfaction are presented below. The survey found that 73% of CAMHD caregivers were satisfied overall with their child's counseling or treatment, which is below the previous years satisfaction in this measure.



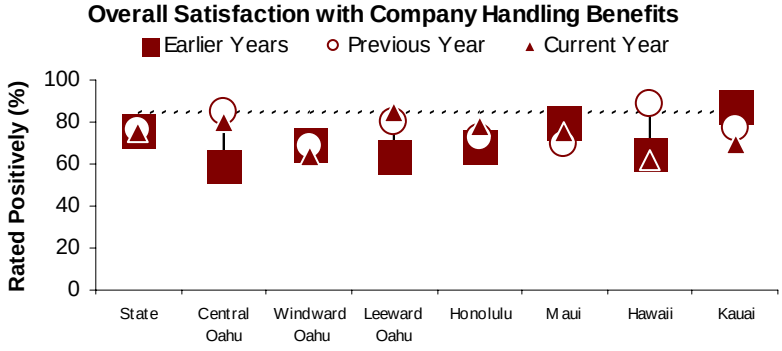
The comparison between calendar years 2004 and 2005 for each Family Guidance Center for satisfaction with counseling/treatment is seen below. Only Central FGC met the performance goal with an observed increase. There was also improvement for the Windward FGC, although the performance goal was not met. There were declines in satisfaction with counseling/treatment for Leeward, Honolulu, Maui, Hawaii, and Kauai.



Another key measure of satisfaction falls under the title of "Overall Satisfaction with the Company Handling Benefits." This question allowed respondents to rate their overall satisfaction with the service system's management of their child's behavioral health care. Results for this indicator fell below targeted performance with 75% of those surveyed satisfied with CAMHD's handling of their child's care, which is slightly below the previous year's performance. The detailed analysis provided in the survey helps CAMHD to identify needed improvements in managing care for consumers.



Results for the individual FGCs in this measure, and a comparison to the previous year's data are presented below. Satisfaction goals were met for Leeward FGC. Improvements in satisfaction with the FGC were seen for Leeward, Honolulu, and Maui FGCs. There was a decline in satisfaction with the FGC for the Central, Windward, Hawaii, and Kauai FGCs.

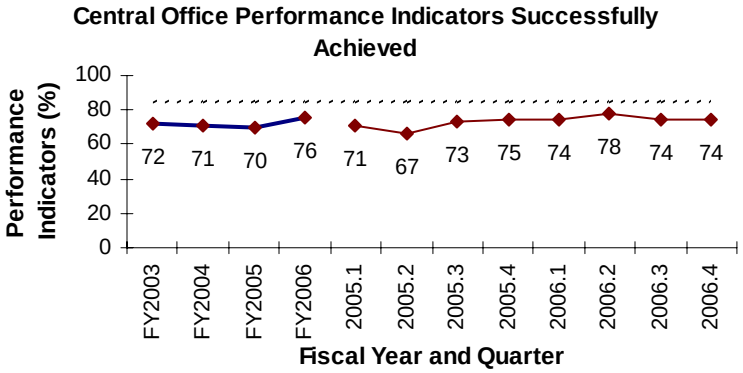


There will be state-level quality performance that ensures effective infrastructure to support the system

Goal:

⇨ **85% of CAMHD Central Office performance measures will be met.**

CAMHD's Central Administrative Offices utilize performance measures for each section for accountability and planning. Central Office measures are approved and tracked by the CAMHD Expanded Executive Management Team (EEMT). There are a total of 36 measures currently tracked by EEMT. Of the 31 measures available in this quarter, 23 or 74% of measures were successfully met, which falls short of meeting the performance goal for this quality indicator and is consistent with last quarter's performance. In the quarter, the measures that fell below their goals continued to be related to timeliness of work products impacted by staff vacancies.

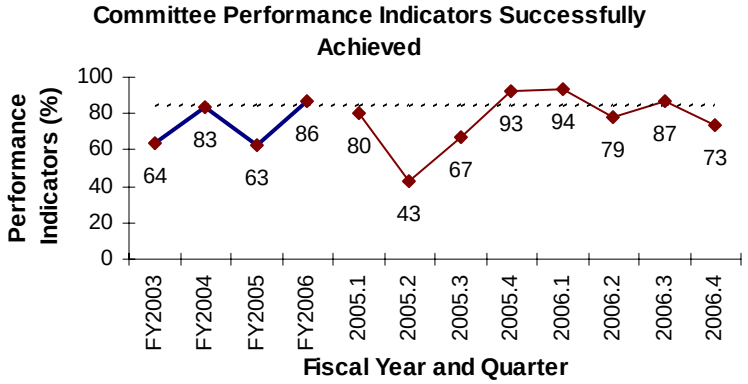


Improvements for Central Office performance measures are managed by respective sections of CAMHD. When solutions require a broader organizational intervention, these are discussed at the Expanded Executive Management Team level, and are tracked for implementation.

Goal:

⇨ **85% of CAMHD State Committees performance measures will be met.**

The CAMHD Performance Improvement Steering Committee (PISC) reviews data for its core committees, which include Grievance Appeals, Compliance, Credentialing, Evidence Based Services, Information System Design, Policy & Procedure, Safety & Risk Management, Training, and Utilization Management.



A total of 20 measures are tracked and reported on in the monthly meeting. Similar to Central Office measures, results for each indicator are discussed in PISC meetings in order to identify improvement strategies that are implemented by respective CAMHD section managers.

In the quarter, of the 15 measures with available data, 73% were successfully achieved through the work of the CAMHD Committees. This is a decrease over last quarter's performance of 87% of measures met. There were four committee measures not meeting the benchmark Compliance, Credentialing (2), and Evidence Based Services. Each committee not meeting their benchmark is required to present improvement strategies to PISC.

Summary

Slightly more than half of performance goals were met or exceeded in the fourth quarter of fiscal year 2006 (April 2006-June 2006), a decrease over last quarter's overall performance.

For a point of reference, the asterisked measures are those that had historically been linked to Federal Court benchmarks under the Felix Consent Decree. Of these "Sustainability" measures, indicators met the performance goal in the reporting quarter except for the following measures:

- Filled Care Coordinator Positions, which was 10% below targeted performance, and a decrease of 4% from last quarter's performance.
- Filled Central Administration Positions, which was below (19%) the targeted performance goal and 18% lower than last quarter's performance.

The following were measures that met or exceeded goals:

- Care Coordinator caseloads within the range of 1:15-20 youth
- Maintaining services and infrastructure within the quarterly budget allocation
- Contracted providers paid within 30 days
- Timely access to the service array:
  - Youth receiving services within 30 days of request*
  - Youth receiving the specific services identified on their plan*
- Timely and effective response to stakeholder concerns:
  - Youth with no documented complaint received*
  - Provider agencies with no documented complaint received
  - Provider agencies with no documented complaint about CAMHD performance*
- CAMHD-enrolled youth receiving treatment within the State of Hawaii*
- CAMHD-enrolled youth receiving treatment while living in their home
- Coordinated Service Plan timeliness*
- Coordinated Service Plan quality*
- Performance Indicators met by the Central Family Guidance Center
- Complexes maintaining acceptable scoring on Internal Reviews*
- Monitoring of provider agencies
- Quality service provision by provider agencies
- Improvements in child status as demonstrated by CAFAS or ASEBA*

The following measures were below targeted performance with observed decreases, and will require implementation of improvement strategies developed by the appropriate monitoring bodies.

- Filled Care Coordinator positions*
- Filled Central Administration positions*
- Performance Indicators met by the Windward Family Guidance Center
- Performance Indicators met by the Leeward Family Guidance Center
- Performance Indicators met by the Honolulu Family Guidance Center
- Performance Indicators met by the Maui Family Guidance Center
- Performance Indicators met by the Hawaii Family Guidance Center
- Performance Indicators met by the Kauai Family Guidance Center
- Performance Indicators met by the Family Court Liaison Branch

- Child Status as measured by Internal Review Results
- Overall satisfaction with counseling or treatment
- Overall satisfaction with company handling benefits
- State Committee performance indicators
- Central Office performance indicators

Of the 31 performance measures completed during this quarter, only 17 or 55% of performance indicators met or exceeded goals. One measure that did not meet the performance goal last quarter met the goal in the current quarter. Almost half of the measures experienced performance declines. Of the original "Sustainability" measures, two (Filled Care Coordinator positions and Filled Central Administration positions) did not meet the performance goal. This corresponds with the previous reporting quarter, with the exception of one of the measures (Complexes Maintaining Acceptable Scoring on Internal Reviews). Challenges to filling positions remain a core issue impacting performance across functions. Vacancies in the MIS, Administrative Offices, Clinical Services, and Performance Management sections continue to challenge ongoing operations. Additionally, performance areas of concern in the Family Guidance Centers continue to be impacted by vacancies and the time it takes to fill positions.